Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MEDICAL IMAGING OF PLANO 2109 WEST PARKER ROAD SUITE 720 PLANO TX 75023	MFDR Tracking #: M4-05-5478-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: LUMBERMENS MUTUAL CASUALTY CO BOX # 21	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Carrier is not paid according to mfg."

Principal Documentation:

1. DWC060
2. Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $273.99

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Payment of $395.24 was made on 4/30/04. Provider failed to provide evidence of submission for re-consideration."

Principal Documentation:

1. DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/12/2004	F	CPT codes 72275, 76003, 99499	$273.99	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code "F-Fee Guideline MAR reduction."
2. The Division has determined that good cause exists to dismiss this request based on: the Requestor no longer operates an active practice at the above address. The Division was unable to contact the Requestor via telephone attempts; the listed phone number(s) have been disconnected. The health care provider has not provided a current, correct address or contact information in accordance with 28 Tx. Admin. Code section 102.4 (d) and/or 102.5.
3. For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		July 7, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.